PEDIATRIC CASE HISTORY

Child's Name:_____ Date: _____

Mother's Name: _____ Father's Name: _____

Address: _____ City: _____ Prov: _____ Postal Code: _____

H. Phone: _____ Mom's W. Phone: _____ Dad's W. Phone: _____

Cell Phone: _____ Referral: _____

Contact email address:_____

Date of Birth: _____ Age: ____ Birth Weight: _____ Current Weight: _____

Sex: ☐ M ☐ F No. of Siblings: _____ Birth Length: _____ Current Length: _____

Type of Birth: ☐ Normal Vaginal ☐ Forceps ☐ Breech ☐ Caesarian

☐ Home Birth ☐ Birthing Centre ☐ Hospital

Problems During Pregnancy: _____

Problems During Labour/Delivery: _____

APGAR Score: _____ ☐ Jaundice (Yellow) ☐ Cyanosis (Blue)

Congenital Anomalies/Defects: _____

Infant Feeding: ☐ Breast How long? _____ ☐ Bottle ☐ Formula

No. of Hours Sleep per Night: _____ Quality of Sleep: ☐ Good ☐ Fair ☐ Poor

Obstetrician / Midwife: _____ Pediatrician / Family M.D. _____

Date of Last Visit to M.D.: _____ Purpose: _____

_____

Vaccinations: ☐ No ☐ Yes Please List: _____

Pregnancy History: _____

_____

Delivery History: _____

_____

_____

Developmental History: At What Age Did the Child…….

_____ Respond to Sound

_____ Follow an object with his/her eyes

_____ Hold head up

_____ Crawl

_____ Stand

_____ Walk on his/her own

Childhood Diseases:

☐ Chicken Pox ☐ Rubella ☐ Other:_____
☐ Mumps ☐ Rubeola
☐ Measles ☐ Whooping Cough

Surgical History: _____

Medications: _____

Accidents: _____

Has this child ever suffered from:

☐ Dizziness	☐ Backaches	☐ Heart Trouble	☐ Chronic Earaches
☐ Diabetes	☐ Tuberculosis	☐ Hypertension	☐ Cold / Flu
☐ Arthritis	☐ Headaches	☐ Asthma	☐ Allergies
☐ Neuritis	☐ Digestive Disorders	☐ Sinus Trouble	☐ Constipation
☐ Anemia	☐ Rheumatic Fever	☐ Orthopedic Problems	☐ Diarrhea
☐ Poor Appetite	☐ Hyperactivity	☐ Sugar Concentration	☐ Behavioral Problems
☐ Bed Wetting	☐ Convulsions	☐ Paralysis	☐ Muscle Jerking
☐ Fainting	☐ Walking Problems	☐ Broken Bones	☐ Ruptures / Hernias
☐ Neck Problems	☐ Arm Problems	☐ Leg Problems	☐ “Growing Pains”